STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

MG at Kirkland, LLC
Merrill Gardens at Kirkland
1938 Fairview Ave East Ste 300
Seattle, WA 98102

RE: Merrill Gardens at Kirkland License # 2587

Dear Administrator:

This letter addresses Compliance Determination(s) 71680 (Completion Date 01/21/2026) and 68591 (Completion Date 12/02/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/21/2026 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2410-9

The Department staff who did the on-site verification:
Wesler Dumecquias, Community Complaint Investigator

If you have any questions, please contact me at (206)305-3489.

Sincerely,

Jim Sherman

James Sherman, Field Manager
Region 2, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Merrill Gardens at Kirkland
Provider Type: Assisted Living Facility

License/Cert.#: 2587
Intake ID: 200117
Compliance Determination #: 68591
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 11/12/2025 through 12/02/2025
Complainant Contact Date(s): 11/06/2025

Allegation(s):

1. The Named Resident (NR) sustained a bruise during transfer.
2. The NR was fearful with some facility care staff.
3. The facility would discharge the NR due to their behavior.

Investigation Methods:

Sample:	Total residents: 25 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Residents Nursing staff Family members Administrators
Record Reviews:	Incident investigation Facility policies Care plans Assessments Photos emails Incident report Witness statement progress notes

Investigation Summary:

1. The NR had a bruise on their left arm. The facility failed to document in the residents record their investigation, the bruising, their assessment of the bruising and that the staff were monitoring the bruise. Failed practice was identified. A citation was issued for non compliance with WAC 388-78A- 2410 (9) Content of resident records. (See Statement of Deficiencies completion date 12/02/2025.)
2. Interview with the NR showed the NR was not fearful with the staff. The NR indicated that they did not like staff telling them what to do. No concerns with other sampled residents. No failed practice was identified.
3. The NR was not discharged. The facility was working with the family and the NR's Primary Care Doctor in exploring ways to address the NR's behavior. The facility implemented "care in pairs" to ensure the safety of the NR. The facility placed the NR on alert charting and monitoring. No failed practice identified.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 11/12/2025 of:

Merrill Gardens at Kirkland
14 Main St S
Kirkland, WA 98033

This document references the following complaint number(s): 200117

The following sample was selected for review during the unannounced on-site visit: 3 of 25 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

Statement of Deficiencies	License #: 2587	Compliance Determination # 68591
Plan of Correction	Merrill Gardens at Kirkland	Completion Date
Page 2 of 4	Licensee: MG at Kirkland, LLC	12/02/2025

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Jim Sherman
Residential Care Services

12-04-2025
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)

12/8/2025
Date

WAC 388-78A-2410-1 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(9) Documentation consistent with WAC 388-78A-2120 monitoring resident well-being.

This requirement was not met as evidenced by:

Based on observation, interview and Record review, the facility failed to document monitoring for 1 of 1 Resident (Resident 1) who had a bruised arm. This failure resulted in the facility not having records of Resident 1's bruised arm and documentation to show staff monitored the skin issue. This place Resident 1 at risk for worsening condition.

Findings included...

Resident 1

Review of the service plan dated 09/10/2025 showed Resident 1 was admitted to the facility on [redacted]/2024 with multiple diagnoses including [redacted] and was on blood thinner medication (medications that increased risk of bleeding, ranging from minor issues like easy bruising and nosebleeds to severe internal bleeding).

Observation on 11/12/2025 at 2:15 PM showed the outer left forearm of Resident 1 had

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Residential Care Services | Date

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Administrator (or Representative) | Date

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Observation on 11/12/2025 at 2:15 PM showed the outer left forearm of Resident 1 had

a bruise which was approximately 1.5x1.5 inches, about the size of a small fist. The bruised area from the outer edge and close to the center had pink and green-like discoloration. The center had no discoloration.

Review of a photo dated 11/01/2025 showed the discoloration around the area of the bruise was visibly dark red, slowly faded to green-like coloring towards the center, and the center had pink-like discoloration.

Review of an email dated 10/29/2025 from Collateral contact 1 (CC1), to Staff A, Executive Director showed CC1 was informed that Resident 1 had a bruise on their forearm which happened on 10/28/2025 during a transfer from their wheelchair.

On 11/24/2025 at 10:57 AM, Staff B, Resident Care Director, stated that they received an email from CC1 that Resident 1 had a bruise on their arm. Staff B did not document the bruise because they did not consider it an incident and because the bruise was on Resident 1's forearm. Staff B stated that bruising on the resident's upper and lower extremities were normal occurrences. Staff B stated that they did not make an incident report (IR). Staff B later stated that they made an IR on a paper copy. Staff B stated that a week before 10/29/2025, when they received the email from CC1, they went to assess the bruise and repeated an assessment on 10/29/2025. Staff B stated that they did not document their assessment. Staff B stated that there was nothing to document. Staff B stated that the bruise was fading away, and the color was faint pink. Staff B stated that the care staff would monitor the bruise during care and report to them (Staff B) if the bruise was getting worse. Staff B stated that the care staff were not required to document their observation. Staff B stated that they would typically document their monitoring in residents' progress notes.

Review of an undated IR showed it was completed and signed by Staff C, Medtech/Caregiver, on 11/13/2025, a day after the unannounced visit by the Residential Care Services, Department Staff.

Review of Resident 1's Progress notes from 07/20/2025 to 10/21/2025 did not show any records or documentation of the bruise, no alert charting or monitoring notes of the bruise from the care staff and no documentation of Staff B's assessment of the bruise on 10/29/2025 and the week prior to 10/29/2025.

In an email on 11/25/2025 at 11:30 AM, Staff F, Regional Director of health Services, acknowledged that the facility staff failed to document the bruise in Resident 1's record or progress notes.

Statement of Deficiencies	License #: 2587	Compliance Determination # 68591
Plan of Correction	Merrill Gardens at Kirkland	Completion Date
Page 4 of 4	Licensee: MG at Kirkland, LLC	12/02/2025

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Merrill Gardens at Kirkland is or will be in compliance with this law and / or regulation on (Date) 1/12/2026

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) Date 12-8-2025

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Merrill Gardens at Kirkland is or will be in compliance with this law and / or regulation on (Date)_____ .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

_____ _____

Administrator (or Representative) Date